

S. No. 2
M-8-43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21514

State File No.

FILED JUL 10 1945
Registration District No. 238

Primary Registration District No. 6148

Registrar's No. e

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Avert *Chiles Und Co.*
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. ---
In this community days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Stoddard *103*
(c) City or town Avert,
(If outside city or town limits, write "RURAL") *0*
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME DAVID DEAN HARRISON
3. (b) If veteran, name war ---
3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased May 24, 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
--- --- 3 --- hr. --- min.

9. Birthplace Avert, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation ---

11. Industry or business ---

MOTHER FATHER { 12. Name Quinton Harrison
13. Birthplace Arkansas
(City, town, or county) (State or foreign country)
14. Maiden name Lucille Priest
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant Quinton Harrison (Father)

(b) Address Avert, Mo.

17. (a) Burial (b) Date thereof May 27, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomfield, Mo.

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) 6-7-45 (b) Pearl Chure
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26th
year 1945 hour 2:50 minute P. M.
21. I hereby certify that I attended the deceased from MAY 24 19 45 MAY 26 19 45
that I last saw him alive on MAY 26 19 45
and that death occurred on the date and hour stated above.

Immediate cause of death PATEINT FORAMEN OVALE
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: 157
Of operations
Of autopsy

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature [Signature] (M. D. or other) DO
While at work? --- (Specify type of place) Means of injury ---
Address Bloomfield, Mo. Date signed 5-27-45

1150

RECEIVED

District Health Office No. 2,

District File Number 745 878

Date Filed 7-6-45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.
working under my personal supervision.

Signed..... Infant was not embalmed.

Licensed Embalmer No.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.